SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties (KAR 30-10-24). Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the prevailing wage rates for such activities.

ENTER - Name, Social Security Number and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties as defined in KAR 30-10-1a and KAR 30-10-24.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job titles should correspond with those included in the Owner/Related Party Salary Chart (please refer to KAR 30-10-24).

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense lines (121, 122, 221, and 321) in Schedule A.

Totals - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of lines 121, 122, 221, and 321 from Schedule A.

SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

Note: Submit copies of loan agreements and amortization schedules with this cost report for all loans of $5,000 or more. Failure to document interest expense is cause for disallowance. (KAR 30-10-15b). Schedules need to be submitted for related party loans showing the interest paid, check numbers and dates.

Column (1) - Enter the original date and duration of the loan in months.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4, Line 667, must agree with the Balance Sheet, Schedule E.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6, Line 667 must agree with the total interest reported on Schedule A, Lines 160 and 401.

Lines –651-666 - Enter each lender's name, address and the items financed. Indicate whether the interest expense was reported on line 160 or line 401 of Schedule A. If interest expense on a loan is pro-rated to both lines, show the breakdown.

Line 667 - Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, for Lines 651-666 as reported on lines 160 and 401 in Schedule A.

SCHEDULE E - BALANCE SHEET

General: The balance sheet should be prepared from the books of the specific facility for which the cost report is filed. In other words, chain units should report only those balance sheet accounts that relate to the particular facility for which the cost report applies. Subject to the above, the balance sheet must be prepared in conformity with Generally Accepted Accounting Principles. Report all ownership claims that are customarily used by your particular type of entity. A partial listing of these accounts by type of entity follows:

Individual Proprietor	Owner's Capital
Partnership	Partner's Capital Accounts
Not-For-Profit Entities	Fund Balance
Corporation	Common Stock, Additional Paid in Capital, Retained Earnings
Chain Unit – All Chain Units (regardless of type of ownership)	Central or Home Office Account

NOTE: Beginning of period account balances shall be reported for providers allowed to submit projected cost reports.

Lines 705, 706, 707 & 723 - If the amount reported exceeds $10,000, attach a schedule showing the details.

SCHEDULE F - RECONCILIATION OF BEGINNING AND ENDING RESIDUAL BALANCES

General: This schedule explains the change in owner's equity or the fund balance from the beginning to the end of the cost reporting period.

Beginning Balance

Line 751 - Enter the beginning owner's equity or fund balance. This is the total of Column 2 lines 727-729 in the Balance Sheet, Schedule E.

Increase to Owner's Equity or Fund Balance

Line 752 - Enter total revenue from Schedule G, Column 1, Line 822.

Line 753 - Enter the total of cash or other assets transferred or contributed by the owners.

Line 754 - Enter the total of cash or other assets transferred or contributed by the central office.

Line 755 - Enter the proceeds from the sale of common stock.

Line 756 & 757 - Enter and specify all other transactions which increase the residual owner equity or fund balance accounts.

Line 758 - Enter the total of Lines 752-757.

Decreases to Owner's Equity or Fund Balance

Line 761 - Enter the total expenses per Schedule A, Column 2, Line 599.

Line 762 - Enter total of cash or other assets withdrawn by the owners but not reported in the Expense Statement, Schedule A.

Line 763 - Enter total cash or other assets withdrawn by the central office.

Line 764 - Enter the total of duly declared dividends paid to stockholders.

Line 765 - Enter the depreciation expense in excess of the straight line method unless reflected as a negative adjustment in Schedule A, Line 404, Column 3.

Line 766 & 767 - Enter and specify all other transactions which decrease the residual owner equity or fund balance accounts.

Line 768 - Enter the totals of Lines 761-767.

Ending Balance

Line 769 - Enter the net of adding lines 751 and 758 and subtracting line 768. The balance at the end of the period (line 769) should equal the total of Column 4, lines 727-729 in the Balance Sheet, Schedule E.

SCHEDULE G - REVENUE STATEMENT

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported on line 821. The amount of the total revenue entered on line 822, Column 1 must also be entered on line 752, Beginning and Ending Residual Balances Reconciliation, Schedule F.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. **Note the Following:** The amount of the offset should be the cost of reimbursable expenses. Non-reimbursable items (i.e. Vending) are offset at cost.

Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 3, Provider Adjustments, on the Expense Statement, Schedule A.

Line 807 - Routine Nursing supplies sold to private pay residents.
There is no offset required for routine items covered under KAR 30-10-15a that are sold to private pay residents.

Line 810 - Resident Purchases/Non Routine Items Sold - Enter the total of all reimbursements for personal purchases not designated as routine items in KAR 30-10-15a.

Line 817- Adult Day Care/Treatment Income - Enter total revenue from all sources for adult day care and day treatment programs.

Line 820 – Non-Nursing Facility Residential Income – Enter total revenue from assisted living, residential care, and apartments.

SCHEDULE H(1) - STATEMENT OF RELATED ADULT CARE HOME INFORMATION

General: All Kansas facilities operated by common ownership or related parties shall be listed. Common ownership and related parties are defined in KAR 30-10-1a. Additional schedules shall be attached as necessary. If the provider is a publicly held entity, provide the annual report and a Form 10-K.

SCHEDULE H(2) – STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

General: Indicate any non-resident related activities that you participate in at the facility for which you are reporting by marking yes in column (1). If adjustments were made on schedule A for any of these activities indicate so by marking yes in column (2). List additional activities that are not identified on the lines provided. Attach a separate schedule if additional room is required.

SCHEDULE I - FIXED ASSET, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

General: Each question shall be answered completely and accurately.

Lines 902-909 - Complex Capital Structures:

Attach a complete explanation of the ownership/management structure of the nursing facility including owners with 5% or more interest in the property and/or business, related parties as defined in KAR 30-10-1a, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the adult care home.

Line 911 - If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be submitted and on file with the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 914 - A new provider that purchases a facility shall submit a copy of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 915 - Submit a copy of the detailed depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method. If the provider has filed a detailed depreciation schedule with the agency, an annual submission of addition and deletion schedules and a summary of depreciation expense are permissible.

SCHEDULE J - EMPLOYEE TURN OVER REPORT

Column 2 - Show the total number of employees at the beginning of the cost report period for each classification.

Column 3 - Show the total number of employees hired during the cost report period for each classification.

Column 4 - Show the total number of employees who ended employment during the cost report period for each classification.

Column 5 - Show the total number of employees at the end of the cost report period for each salary classification.

Column 6 - From the total number of employees listed in column 5, show how many are full-time and how many are part-time.

Column 7 – From the total number of employees listed in column 5, show how many were included in column 2 as employees at the beginning of the cost report period.

The number of employees listed in column 2, plus the number of employees listed in Column 3, less the number of employees reflected in Column 4, should equal Column 5. Please explain any discrepancy. The W-2's are an excellent source of information for the calendar year end cost report.

ATTENTION

The cost report is not considered complete unless all required documents are submitted with the cost reports. Review the list of questions/documents following Schedule J in the Cost Report.

DECLARATION STATEMENT

Declaration by Owner; Partner; or Officer of the Corporation, City or County which is the Provider. The cost report is not considered complete unless signed by an owner or authorized agent of the facility and/or business and the preparer. If person signing is not an owner or partner, documentation or a resolution stating their authority to sign needs to be attached. It is not required, if it has been submitted previously and has not changed. If the facility/business owner and the preparer are the same individual, please sign both spaces. Print the names of the owner/authorized agent and preparer in the space provided. **PLEASE READ DECLARATION STATEMENT.**

EXCEL VERSION

MS-2004

State of Kansas
Department of Social and Rehabilitation Services/
Department on Aging

Rev. 8/02

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

SEND TO KANSAS DEPARTMENT ON AGING	AGENCY USE ONLY			
New England Building	(1,2)		RETRO ADJUSTMENT	
503 S. Kansas Avenue	(3,4)		FULL	PARTIAL
TOPEKA, KANSAS 66603-3404	(5,6)			

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

PROVIDER ID NUMBER (NEED 10 DIGITS) 0	11 EMPLOYERS' FEDERAL ID NUMBER 0
12. PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.) 0	13. FACILITY NAME 0
14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP) 0 0 0 0	

16. ADMINISTRATOR'S NAME 0	17a. PHONE NUMBER 0	18. EMAIL ADDRESS 0	
	17b. FAX NUMBER 0	19. REPORT PERIOD 01/00/00 TO 01/00/00	20. FISCAL YEAR END 01/00/00

CHECK ONLY ONE	21. ___ EXISTING FACILITY (HISTORICAL)	22. ___ NEW PROVIDER (PROJECTED)
	23. ___ NEW FACILITY (PROJECTED)	24. ___ HISTORICAL P/Y SAME AS PROJECTED/1ST YEAR PERIOD
	25. ___ HISTORICAL F/Y OVERLAPS PROJECTION/1ST YEAR PERIOD	
CHECK ONLY ONE	26. ___ SOLE PROPRIETORSHIP	27. ___ PARTNERSHIP 28. ___ CORP - PROFIT
	29. ___ CORP. - NON PROFIT	30. ___ CITY OWNED 31. ___ COUNTY OWNED
	32. ___ OTHER - GOVERNMENT OWNED	33. ___ OTHER (SPECIFY)

NURSING FACILITY BEDS	BED INCREASE OR DEC.	DATE OF CHANGE	BED COUNT	BED DAYS AT THIS BED COUNT
43. NURSING FACILITY OR NF-MENTAL HEALTH BEDS AT THE BEG. OF THE PERIOD			0	0
	43a. 0	0	0	0
	43b. 0	0	0	0
	43c. 0	0	0	0
	43d. 0	0	0	0
45. TOTAL NF OR NF-MH LICENSED BEDS AT THE END OF THE PERIOD				0
46. TOTAL BED DAYS AVAILABLE (TOTAL OF BED DAYS AT THIS COUNT COLUMN FROM LINES 43 THROUGH 43d)				0
48. TOTAL NURSING FACILITY /NFMH RESIDENT DAYS (ALL RESIDENTS FROM AU-3902 DISKETTE)			(4)	0
48a. TOTAL MEDICAID DAYS			(5)	0
48b. TOTAL MEDICARE DAYS				0

OTHER FACILITY BEDS	BEGINNING OF PERIOD	BED INCREASE OR DEC.	DATE OF CHANGE	END OF PERIOD
49. ASSISTED LIVING/RES. CARE	0	0	01/00/00	0
50. UNLICENSED BEDS	0	0	01/00/00	0
51. OTHER RESIDENTIAL DAYS WITH SHARED NURSING FACILITY COSTS (ALL RESIDENTS FROM AU-3903 DISKETTE)				0
52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS?	☐ YES	☐ NO	IF YES, COMPLETE 48b	
53. IS THIS FACILITY (please check one):	☐ HOSPITAL BASED LTCU		☐ FREE-STANDING NF	

This form Supersedes Form MS-2004, Rev. 12/01

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EXCEL VERSION MS-2004

DO NOT CROSS OUT OR RETITLE LINES
DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER
0

SCHEDULE A EXPENSE STATEMENT

OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARY - ADMINISTRATOR	101	0	$0	$0	$0		$0
SALARY - CO ADMINISTRATOR	102	0	$0	$0	$0		$0
OTHER ADMINISTRATIVE SALARIES	103	0	$0	$0	$0		$0
PLANT OPERATING SALARIES	104	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	119	[redacted]	$0	$0	$0		$0
OWNER/RELATED PARTY ADMIN COMPENSATION - SCHEDULE C	121	[redacted]	$0	$0	$0		$0
OWNER/RELATED PARTY PLNT OP COMPENSATION - SCHEDULE C	122	[redacted]	$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	125	[redacted]	$0	$0	$0		$0
CONTRACTED LABOR	130	[redacted]	$0	$0	$0		$0
MANAGEMENT CONSULTANT FEES	131	[redacted]	$0	$0	$0		$0

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JUL 2 6 2004

EXCEL VERSION MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER 0

SCHEDULE A EXPENSE STATEMENT

OPERATING COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
ALLOCATION OF CENTRAL OFFICE COSTS (SEE INSTRUCTIONS)	151		$0	$0	$0		$0
OFFICE SUPPLIES & PRINTING	152		$0	$0	$0		$0
PHONE & OTHER COMMUNICATION	153		$0	$0	$0		$0
TRAVEL	154		$0	$0	$0		$0
ADVERTISING AND RECRUITMENT	155		$0	$0	$0		$0
LICENSES & DUES	156		$0	$0	$0		$0
ACCOUNTING & DATA PROCESSING	157		$0	$0	$0		$0
LIABILITY INSURANCE	158		$0	$0	$0		$0
OTHER INSURANCE (EXCEPT LIFE)	159		$0	$0	$0		$0
INTEREST (EXCEPT RE LOANS)	160		$0	$0	$0		$0
LEGAL	161		$0	$0	$0		$0
CRIMINAL BACKGROUND CHECK	162		$0	$0	$0		$0
REAL & PERSONAL PROPERTY TAX	163		$0	$0	$0		$0
MAINTENANCE & REPAIRS	164		$0	$0	$0		$0
OPERATING SUPPLIES	165		$0	$0	$0		$0
SMALL EQUIPMENT (SEE INSTRUCTIONS)	166		$0	$0	$0		$0
OTHER (PLEASE SPECIFY)	181		$0	$0	$0		$0
TOTAL OPERATING COST CENTER	190	0	$0	$0	$0	$0	$0

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EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

PROVIDER NUMBER
0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A **EXPENSE STATEMENT**

INDIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (5)
DIETARY SALARIES	201	0	$0	$0	$0		$0
HOUSEKEEPING SALARIES	202	0	$0	$0	$0		$0
LAUNDRY SALARIES	203	0	$0	$0	$0		$0
MEDICAL RECORDS SALARIES	204	0	$0	$0	$0		$0
OCCUPATIONAL THERAPIST SALARIES	205	0	$0	$0	$0		$0
PHYSICAL THERAPIST SALARIES	206	0	$0	$0	$0		$0
PSYCH. THERAPIST SALARIES	207	0	$0	$0	$0		$0
RECREATIONAL THERAPIST SALARIES	208	0	$0	$0	$0		$0
RESPIRATORY THERAPIST SALARIES	209	0	$0	$0	$0		$0
SPEECH THERAPIST SALARIES	210	0	$0	$0	$0		$0
RESIDENT ACTIVITIES SALARIES	211	0	$0	$0	$0		$0
SOCIAL WORKER SALARIES	212	0	$0	$0	$0		$0
OTHER IHC SALARIES (SPECIFY)	213	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	219						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C	221		$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	225		$0	$0	$0		$0
CONTRACTED LABOR	230		$0	$0	$0		$0
DIETARY CONSULTANT	231		$0	$0	$0		$0
MEDICAL RECORDS - CONSULTANT	232		$0	$0	$0		$0
OCCUPATIONAL THERAPY - CONSULTANT	233		$0	$0	$0		$0
PHARMACIST - CONSULTANT	234		$0	$0	$0		$0
PHYSICAL THERAPY - CONSULTANT	235		$0	$0	$0		$0
RESPIRATORY - CONSULTANT	236		$0	$0	$0		$0
SPEECH THERAPY - CONSULTANT	237		$0	$0	$0		$0
OTHER CONSULTANT (SPECIFY)	238		$0	$0	$0		$0

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EXCEL VERSION

MS-2004

DO NOT CROSS OUT OR RETITLE LINES

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

PROVIDER NUMBER
0

SCHEDULE A EXPENSE STATEMENT

INDIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
UTILITIES	251	[redacted]	$0	$0	$0		$0
FOOD	252	[redacted]	$0	$0	$0		$0
DIETARY SUPPLIES	253	[redacted]	$0	$0	$0		$0
LINEN & BEDDING MATERIAL	254	[redacted]	$0	$0	$0		$0
LAUNDRY & LINEN SUPPLIES	255	[redacted]	$0	$0	$0		$0
HOUSEKEEPING SUPPLIES	256	[redacted]	$0	$0	$0		$0
RESIDENT ACTIVITY SUPPLIES	257	[redacted]	$0	$0	$0		$0
RESIDENT TRANSPORTATION	258	[redacted]	$0	$0	$0		$0
BARBER AND BEAUTY	259	[redacted]	$0	$0	$0		$0
NURSE AIDE TRAINING	260	[redacted]	$0	$0	$0		$0
OTHER HEALTH CARE TRAINING	261	[redacted]	$0	$0	$0		$0
OTHER (PLEASE SPECIFY)	281	[redacted]	$0	$0	$0		$0
TOTAL INDIRECT HEALTH CARE COST CENTER	290	0	$0	$0	$0		$0

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EXCEL VERSION MS-2004

DO NOT CROSS OUT OR RETITLE LINES

PROVIDER NUMBER 0

DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.

SCHEDULE A — EXPENSE STATEMENT

DIRECT HEALTH CARE COST CENTER	LN#	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
LICENSED MENTAL HEALTH TECH SALARIES	301	0	$0	$0	$0		$0
LICENSED PRACTICAL NURSE SALARIES	302	0	$0	$0	$0		$0
MEDICATION AIDE SALARIES	303	0	$0	$0	$0		$0
NURSE AIDE SALARIES	304	0	$0	$0	$0		$0
REGISTERED NURSE (RN) SALARIES	305	0	$0	$0	$0		$0
RESTORATIVE/REHAB AIDE SALARIES	306	0	$0	$0	$0		$0
EMPLOYEE BENEFITS	319		$0	$0	$0		$0
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C	321		$0	$0	$0		$0
OWNER/RELATED PARTY EMPLOYEE BENEFITS	325		$0	$0	$0		$0
CONTRACTED NURSING LABOR	330		$0	$0	$0		$0
NURSING CONSULTANTS	331		$0	$0	$0		$0
NURSING SUPPLIES	351		$0	$0	$0		$0
TOTAL DIRECT HEALTH CARE COST CENTER	390	0	$0	$0	$0		$0
TOTAL RATE FORMULA COSTS	399	0	$0	$0	$0		$0
OWNERSHIP COST CENTER							
INTEREST - REAL ESTATE	401		$0	$0	$0		$0
RENT/LEASE EXPENSE	402		$0	$0	$0		$0
AMORTIZED LEASEHOLD IMPROVEMENT	403		$0	$0	$0		$0
DEPRECIATION EXPENSE	404		$0	$0	$0		$0
TOTAL OWNERSHIP COST CENTER	490		$0	$0	$0	$0	$0